pupils were normal. The knee and ankle jerks were absent. The electrical reactions were reduced, with some qualitative change, particularly in the hypertrophied muscles. There seemed to be no trouble of the special senses, and the child's mentality was apparently normal.

Dr. Terriberry said that these cases probably belong to the category of hereditary muscle disease or weakness which usually did not appear for some time after birth, the profundity of the hereditary shortcoming probably causing the early appearance of the myopathy, this early appearance being undoubtedly exceedingly rare.

A CASE OF HERPETIC INFLAMMATION OF THE GENICULATE GANGLION, WITH FACIAL PALSY AND ACOUSTIC SYMPTOMS.

By Dr. J. Ramsay Hunt.

The speaker said that at a meeting of the American Neurological Association held in Boston, June 4, 1906, he presented a new syndrome dependent upon a herpetic inflammation of the geniculate ganglion of the facial nerve. (Posterior poliomyelitis of Head and Campbell.)

The immediate proximity of this ganglion to the facial and the auditory nerves in the depths of the internal auditory canal, and their common sheath, would explain the frequency of facial and auditory symptoms in this group of cases, the inflammatory process extending to the facial and in some instances to the auditory and its terminations.

The syndrome resolved itself into three clinical groups: 1. Herpes auricularis. 2. Herpes auricularis and facial palsy. 3. Herpes auricularis, facial palsy and auditory symptoms.

The zoster zone for the geniculate was situated in the interior of the auricle (concha, external auditory canal and the tympanum). The geniculate zone was therefore intercalated between the Gasserian zone in front and that of the second and third cervical ganglia behind.

The following case was a typical one of this affection: The patient was a man, 30 years old, an upholsterer. On Saturday evening, February 16, 1907, he was seized with sharp, shooting pains in and behind the left ear. On Sunday the pains were more severe; on Monday and Tuesday the pains were very severe, and so intense at night as to prevent sleep. They were tearing and shooting in character, chiefly in the external auditory canal, but also in the occipital, temporal, and facial distributions. The throat and ear were examined on Tuesday, with negative results. About this time the auricle became somewhat swollen and reddened, and looked as if frost-bitten. It was tender, and he was unable to sleep on that side. He kept the whole left side of the face protected by a dressing, as any draught brought on an attack of pain. On the 19th of February the face was noticed to be paralyzed on the left side, and about the same time his wife noticed a few groups of white vesicles in the interior of the auricle. He had no tinnitus aurium, no vomiting or disturbance of equilibrium, and the diminution of hearing was not observed by the patient until special tests were carried out.

Status Præsens: On February 27, 1907, there was complete palsy of the 7th nerve, in all its branches, with sagging and drooping of the parts, and the patient was unable to close the left eyelid. For a few days after the onset he had an overflow of the tears (epiphoria), but this had not been present during the past week. Taste was lost over the anterior two-thirds of the tongue on the left side.

Sensation: All sensations were preserved over the left side of the face, the left ear and in the region of the occiput and neck. On comparing the sensations on the two sides, a slight diminution was demonstrable on the left side of the entire cephalic extremity, face, head and neck, including the mucous membranes, sharply demarcated in the middle line. The corneal and conjunctival reflexes were present, but diminished on the left. The aural reflex was diminished on the left. There was no tenderness over the points of exit of the trigeminal or occipital nerves.

Herpetic symptoms: The vesicles had coalesced and formed two plaques, each situated on a reddened base and exuding serum. The smaller of these plaques was situated on the inferior border of the external auditory meatus at its entrance; the other was concealed beneath the fold of the anthelix in its superior portion. The canal and the tympanum were free. The orifice of the canal was still slightly swollen, and smaller than the right. No evidence of herpes was noted elsewhere about the face or neck. The aural examination was made by Dr. McAuliffe. In the left ear, the hearing was diminished one-half, as compared with the right side. The partial deafness was of the central type (nerve deafness). No tinnitus; drum membrane normal. The tear sensation tested on March 8, 1907 (oil of mustard) was normal, and equal on the two sides. The examination of the other cranial nerves, and the neurological examination in general, namely, reflexes, motility, sensation, etc., were negative, as were the internal organs, urine and blood.

Electrical examination, March 7, 1907: The indirect reactions of the left facial showed a slight quantitative increase to both currents. Directly applied, the responses were somewhat diminished. No qualitative changes.

Notes on the course of the disease: On March 15, 1907, the pains had gradually diminished in intensity and had practically disappeared. The most troublesome were those shooting into the external auditory canal. The 7th palsy improved very rapidly and by March 15th only a trace of it remained. (This was one month from the time of onset.) The sense of taste was completely restored. The hearing on March 8 showed only a diminution of one-quarter as compared with the normal right side, and on the 15th, hearing was equal on the two sides. Two small depressed scars marked the seat of the herpetic manifestations.

Remarks: Dr. Hunt said this group of cases was characterized by the severity and intense neuralgic character of the pains. (Pre-herpetic and post-herpetic neuralgia.) Also by the occurrence of the herpes zoster. While the pain in rheumatic facial palsy might endure for a fortnight or more, it never reached the same degree of intensity as in these cases. In many cases the zone was in the trifacial or in the occipito-cervical distribution, and not in the geniculate area.

Dr. Dercum said Dr. Hunt had so clearly analyzed these cases, and had placed the matter in so definite and unmistakable a light, that he thought there was very little to be said on the subject. Dr. Hunt had certainly established a new medical group, and one that was most suggestive.

Dr. Sinkler said the nearest approach he had ever seen to the condition described by Dr. Hunt was a case of facial palsy slightly preceded by a herpetic eruption, or rather a discrete eruption of a vesicular character on the scalp and about the auricle, and with pain in the auricle.

Dr. Gordon expressed his admiration for Dr. Hunt's new syndrome, which he thought might properly be termed "Hunt's disease."

DEMONSTRATION OF GLASS MODELS OF BRAIN LESIONS.

By Dr. Adolf Meyer.

The speaker said that one of the chief aims of a central plant, such as the Pathological Institute of the New York State Hospitals, must be to conduct research work in such a manner as to make it a help and a stimulous to the hospital physicians in their actual work, as much as an achievement in the field of disputed points, or satisfaction along the lines of more personal problems; every problem of investigation was, of course, something like an individual query, but the results would not answer their purpose unless we got them into such form that they pass readily into the fund of practical resources which our hospital physicians need in order to outgrow the routine in which they might too readily lose the best opportunities. This was by no means an easy task in that one of its fields of work which he wished to demonstrate briefly to-night. Brain anatomy has at best a verbal interest with most physicians. It becomes, therefore, especially necessary to devise means of presentation which will make the facts easy of grasp and telling, and an improvement on the ponderous volumes out of which we ourselves had to dig our knowledge of the work of the past.

The glass-models represented an idea which had occurred to many (they are, for instance, used by geologists), but which had not to his knowledge been used in brain anatomy as systematically before. In purely morphological work, with its interest in surfaces, the wax-plates have their special field; but to topographical work with its many interlacing fiber tracts, the glass-model method is so far unrivaled.

The color schemes used were more or less accidental, and determined by what Higgins' inks offered. The choice happened to coincide to quite an extent with Barker's, and with the recent work of Johnston. It was indeed attempted to come to an agreement, and to propose a scheme of colors to facilitate a certain uniformity in the presentation for students.

In the study of the brain-stem of a case of traumatic destruction of one-half of the pons, the segmental efferent or motor nerves are to be found in brick-red; the pyramids in carmine; the segmental afferent or sensory nerves in blue tinges (Higgins' true blue for V, cochlear, IX, X; indigo for the vestibular); the cerebral afferent paths, green for the mesial fillet (destroyed on one side), and violet for the trapezium and lateral fillet. The cerebellar systems appear in yellow, orange and browns; the central tegmental bundle of vermilion, etc.

In the forebrain a kindred color-scheme was used, as was shown in the two cases of reconstruction of occipital lobes, in which the geniculo-calcarine tract appears in blue, the geniculo-temporal in violet; the occipito-temporal afferent paths in vermilion, the callosum in violet, the lenticular complex in indigo, etc.

The original drawings were, of course, hard work; but together with